Tennessee's Family Services Counseling Assessment Form
Screening/Assessment Instrument

The Family Services Counseling (FSC) Assessment Form is a standard tool used statewide by all family services counselors. The assessment was developed by the program director with input from welfare and FSC program staff. Family services counselors may use additional inventories but are required to complete the basic assessment form for all clients referred to the FSC program. Copies of completed assessment forms are sent to the College of Social Work, Office of Research and Public Service at the University of Tennessee for use in the FSC program evaluation.

Purpose of the screening/assessment tool: The purpose of the assessment is to determine the service needs of TANF recipients participating in the FSC program. Results from the assessment are used to design the types and volume of activities included in the client's employment plan. This assessment is also used in a statewide evaluation of the FSC program.

Target population: The FSC Assessment Form is administered to TANF recipients referred to the FSC program, which includes those with mental health and substance abuse problems, victions of domestic violence, individuals with learning disabilities, and/or children with behavioral problems. Clients in sanction status are automatically referred to FSC (participation in services is voluntary).

Who administers the assessment: The assessment is administered by family services counselors, who are either licensed mental health professionals or individuals supervised by a licensed mental health professional.

Time required to complete the assessment: On average, assessments take about two hours to complete.

Information collected/issues addressed: The FSC Assessment Form collects information on demographics, family situation, sources of stress, problems the client is struggling with, school/work history, physical health, counseling history, drug and alcohol use, current functioning, and on issues covered in the Adult Strength Scale.[2] Counselors also recorded their impressions and recommendations on the form. In addition, the form includes four supplemental screenings: (1) learning needs screening, (2) drug and alcohol screening, (3) family violence screening, and (4) functional assessment.[3] These screenings are only used if certain "red flag" questions on the assessment are answered positively or if the counselor believes that additional questions may help the client open up and disclose more information.

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[2] The Adult Strength Scale includes questions on home, work/school/training, emotional, and social resources and strengths.

[3] Sections in the functional assessment are understanding and memory, sustained concentration and persistence, social interaction, and adaptation.

Family Services Counseling
Assessment Form

DEMOGRAPHIC INFORMATION

1. Customer Name: _____
   (Last) (First) (MI)
2. Case/Cat/Seq: _____ /ADC__ / _____
3. Recipient ID: _____
4. Social Security #: _____ - _____ - _____
5. ____ Marital Status:
   1. Divorced
   2. Married, Living w/ Spouse
   3. Married, but Separated
   4. Single, Never Married
   5. Widowed
   6. Other _____
6. Date of Birth: ____ / ____ / ____
   mm dd yy
7. ____ Gender
   1. Male 2. Female
8. ____ Ethnicity –Hispanic or Latino
   1. No 2. Yes
9. ____ Race:
   1. American Indian/Alaskan Native
   2. Asian
   3. Black or African American
   4. Native Hawaiian or other Pacific Islander
   5. White
   6. Other, specify _____

SOURCES OF STRESS "What brings you here today?"

Please list the reasons that bring the customer here today. This may include certain problems, issues, significant losses or changes that are causing stress in their life.

10A. _____

10B. _____

10C. _____

10D. _____

ADULT STRENGTH SCALE

Please have the customer complete the following Adult Strength Scale. In the event the customer is not able to fill the scale out individually, please read each statement to the customer and circle their response.
It may be helpful to substitute a scale of "1 to 5" when reading the questions to the customer, 1 being never and 5 being all the time.

11. _____ The Adult Strength Scale was
    1. Completed by the customer
    2. Read to the customer

ADULT STRENGTH SCALE

Please read the following questions and circle the answer that most closely describes your situation.

	Never (1)	Just a Little (2)	Not Sure (3)	Pretty Much (4)	Very Much (5)	N/A (0)
Home						
12. My family is a source of support for me	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
13. I get along with my partner/ significant other	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
14. I am physically healthy	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
15. I am a good parent	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
Work/School/Training						
16. I get to my activity on time	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
17. I get along with my co-workers/ classmates	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
18. I am respected by my supervisor(s)/ teacher(s)	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
19. I enjoy working	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
20. I have work/training goals	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
21. I am a hard worker	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
22. I balance home and work/school	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
23. I can pay attention to what I'm doing	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
Emotional						
24. I cope well when things are bad	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
25. I am satisfied with life	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
26. I accept responsibility for my mistakes	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
27. I think before I act	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
28. I have good self-esteem	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
Social						
29. I make and keep friends	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
30. I stand up for myself	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
31. I get along with others	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
32. My community is a source of support for me	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A
33. I attend church or another organization	Never	Just a little	Not Sure	Pretty Much	Very Much	N/A

PROBLEMS THAT YOU ARE STRUGGLING WITH

Please read each choice to the customer and check ( ) all that apply

34. ( ) Difficulty meeting your family's basic needs (such as food, clothing, housing)
35. ( ) Childcare
36. ( ) Transportation
37. ( ) Child behavioral problem
38. ( ) Child health problem
39. ( ) Stress
40. ( ) Unemployed
41. ( ) Physical health
42. ( ) Job/school problem
43. ( ) Low self - esteem
44. ( ) Anger/temper problems
45. ( ) Communication problems
46. ( ) Marital/relationship problems
47. ( ) Legal problems
48. ( ) Probation
49. ( ) Compulsive gambling
50. ( ) Learning problem/disability
51. ( ) Racism
52. ( ) Death of a loved one
53. ( ) Major losses/difficult changes
54. ( ) Sleeping problems
55. ( ) Eating problems
56. ( ) Depression
57. ( ) Anxiety or panic attacks
58. ( ) Nerve problems
59. ( ) Sexual Abuse - Adult/Child
60. ( ) Suicidal, or thoughts of hurting yourself
61. ( ) Suicidal actions
62. ( ) Thoughts of hurting someone else
63. ( ) Rape survival
64. ( ) Violence in family-actual or threatened
65. ( ) Alcohol
66. ( ) Drugs
67. ( ) Other_____

Additional Space (interviewer comments if needed):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SCHOOL/WORK HISTORY

Please ask the customer the following questions and indicate their response in the space provided.

68. ____ Did you have any problems learning in elementary, middle school or junior high school?
1. No 2. Yes

69. ____ What is the highest grade you completed? *(circle the number of the highest grade completed)*
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

70. ____ Did you have one of the following?
1. Certificate
2. Diploma
3. GED
4. N/A – did not graduate from high school

71. ____ Were you in a special education or "resource" class at any point in school?

1. No 2. Yes

72. ____ Are you currently a student?
1. No 2. Yes

If No, go to question 74. If Yes, answer question 73.

73. ____ In what kind of education/training are you currently enrolled?

1. High school
2. GED/ABE classes
3. Job training (*specify*) _____
4. Other (*specify*) _____

74. ____ Have you ever been employed?
1. No 2. Yes

If No, go to question 77. If Yes, answer question 75 and 76.

75. ____ How many months have you worked during the past 12 months?

76. ____ Do you have a job right now?
1. No 2. Yes

HEALTH

Please ask the customer the following questions and indicate their response in the space provided.

77. ____ Do you currently have any diagnosed physical/emotional/medical conditions?
1. No 2. Yes

If No, go to question 79. If Yes, answer question 78.

78. If Yes, what conditions? (*check all that apply*)

___ 1. Asthma
___ 2. Diabetes/sugar
___ 3. Epilepsy/seizure disorder
___ 4. Head injury or other neurological disorder
___ 5. Hearing loss
___ 6. Disability _____
___ 7. Mental health problems _____
___ 8. Pregnancy
___ 9. Vision impairment
___ 10. High blood pressure
___ 11. Other (*specify*) _____

79. ____ Have you ever been treated for emotional or nerve problems?
1. No 2. Yes

Current medication you regularly take - please include prescription, over the counter, and any herbal remedies (if none, write "None")

Name of Medication

_____
_____
_____
_____
_____

HISTORY OF COUNSELING

Please indicate the customer's response in the space provided.

Previous or Current Counseling (if none, write "None")

Therapist or Agency	From/to	Focus of Counseling

What was helpful and/or not helpful about your previous/current counseling experience?

_____

_____

_____

DRUGS AND ALCOHOL

Please circle the customer's response to the following questions.

80. How often do you have a drink of alcohol?

Never (1) Monthly or less (2) 2-4 times/mo. (3) 2-3 times/wk. (4) 4 or more times/wk. (5)

81. How often do you use drugs?

Never (1) Monthly or less (2) 2-4 times/mo. (3) 2-3 times/wk. (4) 4 or more times/wk. (5)

82. How often during the past year have you found that you drank or used drugs more than you intended to?

Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily (5)

83. How often during the last year have you failed to do what was normally expected from you because of drinking or using drugs?

Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily (5)

84. How often during the last year have you been unable to remember what happened the night before because you had been drinking or using drugs?

Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily (5)

FAMILY INFORMATION

Please ask the customer the following questions and indicate their response in the space provided.

85. Please list the people that you currently live with

Name	Relationship to customer	Age

86. ____ How old were you when your first child was born? (Enter age in years).

87. ____ Are all your children currently living with you?
1. No 2. Yes

If no, please give names and ages

_____

88. ____ Are any of your children having problems such as behavior problems, problems in school, bedwetting, medical problems, etc?
1. No 2. Yes

If yes, which child(ren) and describe the problem(s)_____

_____

_____

_____

89. ____ Has DCS ever been involved with your child(ren)?
1. No 2. Yes

If yes, why _____

_____

_____

_____

90. ____ Have you ever been hit, slapped, kicked, punched or abused in any other way by a friend or loved one?
1. None disclosed at this time 2. Yes

91. ____ Have you ever experienced emotional abuse (name calling, someone telling you that you are no good, stupid, etc.) by a friend or loved one?
1. None disclosed at this time 2. Yes

If yes to questions 90 OR 91, answer question 92. Otherwise, skip to question 93.

92. ____ How long ago did the most recent event happen?
1. Within last six months 2. Six months to 1 year 3. Over a year

CURRENT FUNCTIONING

93. Please read the following statement to the customer and circle their response. "Please think about how you are coping with your current situation. On a scale of 0 to 10, 10 being the best and 0 the worst, what number best describes how you are coping now."

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

GOALS IN COUNSELING

Goals are very important in counseling. They provide a focus and direction to services. Please ask the customer the goal(s) that they hope to address and achieve in counseling. Please be as specific as possible.

94A._____

_____

94B._____

_____

94C._____

_____

94D._____

_____

**********End of Assessment with Customer**********

COUNSELOR IMPRESSIONS

Based on your interview, please indicate whether or not you believe there are barriers to achieving self-sufficiency in the following areas for this customer at this time.

95. ____ Education background
1. No 2. Yes

96. ____ Possible learning disabilities
1. No 2. Yes

97. ____ Work history
1. No 2. Yes

98. ____ Family/parenting needs
1. No 2. Yes

99. ____ Relationships
1. No 2. Yes

100. ____ Child behavioral problems
1. No 2. Yes

101. ____ Family violence
1. No 2. Yes

102. ____ Inadequate basic needs
1. No 2. Yes

103. ____ Family environment and upbringing
1. No 2. Yes

104. ____ Physical health of participant
1. No 2. Yes

105. ____ Physical health of children/family members
1. No 2. Yes

106. ____ Alcohol/drug abuse
1. No 2. Yes

107. ____ Mental health issues
1. No 2. Yes

108. ____ Legal issues
1. No 2. Yes

OUTCOME CATEGORY

109. ____ What is the customer's designated "outcome category"? (circle one category)

A No barriers found, this customer will not receive Family Services Counseling services.
B Slight barriers found. Counselor will provide a few services but customer will still have a traditional work plan (typically 40 or 20 hours).
C Major barriers present that allow for modifications to the total hours on the PRP, modified sanction procedures, time limit interruptions, and/or modified activities.
D Severe barriers present, pursue exemption and/or interruption to time limits; continuation with Family Services Counseling is voluntary; no work or work-related activities are included on the PRP.

110. Family Services Counselor _____

Counselor's signature: _____

111. County: _____

112. Date Completed: _____ / _____ / _____
mm dd yy

Send a copy of the completed report to:

Doris Loveday
UT SWORPS
2101 Terrace Avenue
Knoxville, TN 37996-3504

FAMILIES FIRST
Creating Opportunities For Families

LEARNING NEEDS SCREENING

Screening Date

BACKGROUND INFORMATION

NAME	BIRTH DATE	SEX M F	SSN

Before proceeding to the questions, read this statement aloud to the participant

The following questions are about your school and life experiences. We're trying to find out how it was for you (or your family members) when you were in school or how some of these issues might affect your life now. Your responses to these questions will help identify resources and services you might need to be successful in getting and keeping a job.

SECTION I

YES	NO	
☐	☐	1. Did you have any problems learning in middle school or junior high?
☐	☐	2. Do any family members have learning problems?
☐	☐	3. Do you have difficulty working with numbers in columns?
☐	☐	4. Do you have trouble judging distances?
☐	☐	5. Do you have problems working from a test booklet to an answer sheet?

1 x _____ = _____ ***(Count the number of "YES'S." Multiply by 1).***

SECTION II

☐	☐	6. Do you have difficulty or experience problems mixing arithmetic signs (+/x)
☐	☐	7. Did you have any problems learning in elementary school?

2 x _____ = _____ ***(Count the number of "YES'S." Multiply by 2).***

SECTION III

☐	☐	8. Do you have difficulty remembering how to spell simple words you know?
☐	☐	9. Do you have difficulty filling out forms?
☐	☐	10. Do you (or did you) experience difficulty memorizing numbers?

3 x _____ = _____ ***(Count the number of "YES'S". Multiply by 3).***

SECTION IV

☐	☐	11. Do you have trouble adding and subtracting numbers in your head?
☐	☐	12. Do you have difficulty or experience problems taking notes?
☐	☐	13. Were you ever in a special program or given extra help in school?

4 x _____ = _____ ***(Count the number of YES'S". Multiply by 4)***

_____ TOTAL: If 12 or more, refer for further assessment

This screening is not a diagnostic tool and should not be used to determine the existence of a disability.

The Learning Needs Screening was developed for the Washington State Division of Employment and Social Services Learning Disabilities Initiative under contract by Nancie Payne, Senior Consultant, Payne & Associates, Olympia, Washington.

ADDITIONAL QUESTIONS

It is recommended that counselors ask an additional set of medical/health-based questions to gather more complete background information.

GLASSES

	YES	NO
Does the customer need or wear glasses?	☐	☐
Was last eye exam within two years?	☐	☐

HEARING

	YES	NO
Does the customer need or wear a hearing aid?	☐	☐

MEDICAL/PHYSICAL

Has the customer experienced any of the following?

	YES	NO
Multiple, chronic ear infections	☐	☐
Multiple, chronic sinus infections	☐	☐
Serious accidents resulting in head trauma	☐	☐
Prolonged high fevers	☐	☐
Diabetes	☐	☐
Severe allergies	☐	☐
Frequent headaches	☐	☐
Concussion or head injury	☐	☐
Long-term substance abuse problems	☐	☐
Serious health problems	☐	☐
Is customer taking any medications that would affect the way he/she is functioning?	☐	☐
If yes, what? _____		
How often? _____		
Does customer need medical or follow-up services?	☐	☐
Referrals needed/made: _____		
Has customer ever been diagnosed or told that he/she has a learning disability?	☐	☐
If yes, by whom? _____		
When? _____		

NOTES:

Counselor Signature: _____

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DRUG AND ALCOHOL REFERRAL SCREENING

Screening Date

BACKGROUND INFORMATION

NAME	BIRTH DATE	SEX M F	SSN

This form is a guide to assist you in determining if your customer needs to be referred for a drug or alcohol assessment. It does not determine if the customer is addicted or what treatment is needed. If, after using this form, you suspect that there might be a current or historical problem with drugs or alcohol, ask the customer if they would be willing to talk further with a drug and alcohol treatment provider. If they agree, contact the Families First contracted drug and alcohol treatment provider in your area to make a referral. Include the follow-through with the assessment and participation in treatment as a recommended component on the PRP. You can make drug or alcohol assessment and/or treatment a component of the Personal Responsibility Plan (PRP) if an assessment determines that treatment is needed to make them employable.

SELF-DISCLOSURE

	YES	NO
1. Have you ever thought that you had a problem with alcohol or other drugs?	☐	☐
2. Have you ever lost a job or been refused employment due to drug or alcohol use?	☐	☐
3. Have you ever been in trouble with the law:		
a) for having drugs in your possession?	☐	☐
b) because you or your friends were using alcohol or drugs?	☐	☐
c) for getting money for drugs or alcohol?	☐	☐
d) for assault, domestic violence, resisting arrest, or other behaviors related to your alcohol or other drug use?	☐	☐
e) for child abuse or neglect related to alcohol/drug use?	☐	☐
4. Have you ever been arrested for driving while intoxicated or under the influence of drugs (DWI, DUI, or for Physical Control)?	☐	☐
5. Do you fight or argue with others while under the influence of alcohol or other drugs?	☐	☐
6. Have you ever been to the emergency room or hospitalized as a result of alcohol or other drug use?	☐	☐
7. Have you ever sought help or been in treatment and/or attended a support group for alcohol or other drug use?	☐	☐
8. Has a friend, family member, or anyone ever told you that you drink alcohol or use drugs too much?	☐	☐
9. Do you sometimes not remember things that you said or did while you were drinking or using other drugs?	☐	☐

Any positive answers indicate the potential for a problem with alcohol or other drugs and a referral for assessment by a FFADAT provider is indicated. If the customer is a pregnant woman, in any stage of her pregnancy, she should be referred for an assessment if any answers were positive or there has been any report of the use of alcohol or other drugs since becoming pregnant.

Counselor Notes:

Counselor Signature: _____

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FAMILY VIOLENCE SCREENING

Screening Date

BACKGROUND INFORMATION

NAME	BIRTH DATE	SEX M F	SSN

Before proceeding to the questions, read this statement aloud to the participant

Answering the following questions will help us better serve your family. The questions may be answered simply with a "yes", "no", or "I do not wish to answer at this time." Your answers to these questions will not prevent you from getting benefits. Information you share with me is confidential unless your children are being hurt or there is reason to believe that your children may be in danger. People have many ways of showing they are angry with you. Some of the ways your partner, spouse, or the person you love shows anger toward you may be violent or controlling. Some of the questions I'm going to ask you describe a type of abuse. By answering these questions we can begin to determine if you are in an abusive situation, create a PRP that best meets your needs and not place you in more danger.

	YES	NO	NO COMMENT
1. Does your partner put you down or make you feel bad about yourself?	☐	☐	☐
2. Does your partner tell you what to do or who you can see or talk to?	☐	☐	☐
3. Would your partner try to keep you from going to work support activities or keep you from working?	☐	☐	☐
4. Would your partner or someone from a past relationship harass you at work by following you or calling your job?	☐	☐	☐
5. Are you afraid of your partner, spouse or someone from a past relationship?	☐	☐	☐
6. Are you afraid for you or your children's safety?	☐	☐	☐
7. Have you been threatened by this person?	☐	☐	☐
8. Have you been physically injured by this person?	☐	☐	☐
9. Do you have a restraining order (order of protection) against someone?	☐	☐	☐

If YES, who? _____

If the customer responds "yes" to any of the questions, determine whether a safety plan needs to be completed and give them information about how to contact their local domestic violence program.

If you answered "yes" to any of these questions, you may be in an abusive relationship, and you don't deserve to be. How can we help?

Counselor Notes:

Counselor Signature _____

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FUNCTIONAL ASSESSMENT

NAME OF PATIENT_____ SSN_____

Please evaluate this individual's mental abilities in terms of the individual's capacity to sustain the ability over a normal workday and workweek on an ongoing basis.

	Unable to Determine	Not Significantly Limited	Moderately Limited	Markedly Limited
A. UNDERSTANDING AND MEMORY				
1. The ability to remember work-like procedures.	1 ☐	2 ☐	3 ☐	4 ☐
2. The ability to understand and remember very short and simple instructions	1 ☐	2 ☐	3 ☐	4 ☐
B. SUSTAINED CONCENTRATION AND PERSISTENCE				
3. The ability to carry out very short and simple instructions.	1 ☐	2 ☐	3 ☐	4 ☐
4. The ability to maintain attention for extended periods of two-hour segments.	1 ☐	2 ☐	3 ☐	4 ☐
5. The ability to maintain regular attendance, and be punctual within customary tolerances. (These tolerances are usually strict.)	1 ☐	2 ☐	3 ☐	4 ☐
6. The ability to sustain an ordinary routine without special supervision.	1 ☐	2 ☐	3 ☐	4 ☐
7. The ability to work in coordination with or proximity to others without being unduly distracted by them.	1 ☐	2 ☐	3 ☐	4 ☐
8. The ability to make simple work-related decisions.	1 ☐	2 ☐	3 ☐	4 ☐
9. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1 ☐	2 ☐	3 ☐	4 ☐

	Unable to Determine	Not Significantly Limited	Moderately Limited	Markedly Limited
C. SOCIAL INTERACTION				
10. The ability to ask simple questions or request assistance.	1 ☐	2 ☐	3 ☐	4 ☐
11. The ability to accept instructions and respond appropriately to criticism from supervisors.	1 ☐	2 ☐	3 ☐	4 ☐
12. The ability to get along with coworkers and peers without unduly distracting them or exhibiting behavioral extremes.	1 ☐	2 ☐	3 ☐	4 ☐
D. ADAPTATION				
13. The ability to respond appropriately to changes in a routine work setting.	1 ☐	2 ☐	3 ☐	4 ☐
14. The ability to be aware of normal hazards and take appropriate precautions.	1 ☐	2 ☐	3 ☐	4 ☐

Please describe the mental impairments, which are the source of any limitations noted above:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SIGNATURE: _____ DATE: _____
PHYSICIAN OR PSYCHOLOGIST

ADDRESS: _____
_____
_____
_____

PHONE: _____
FAX: _____